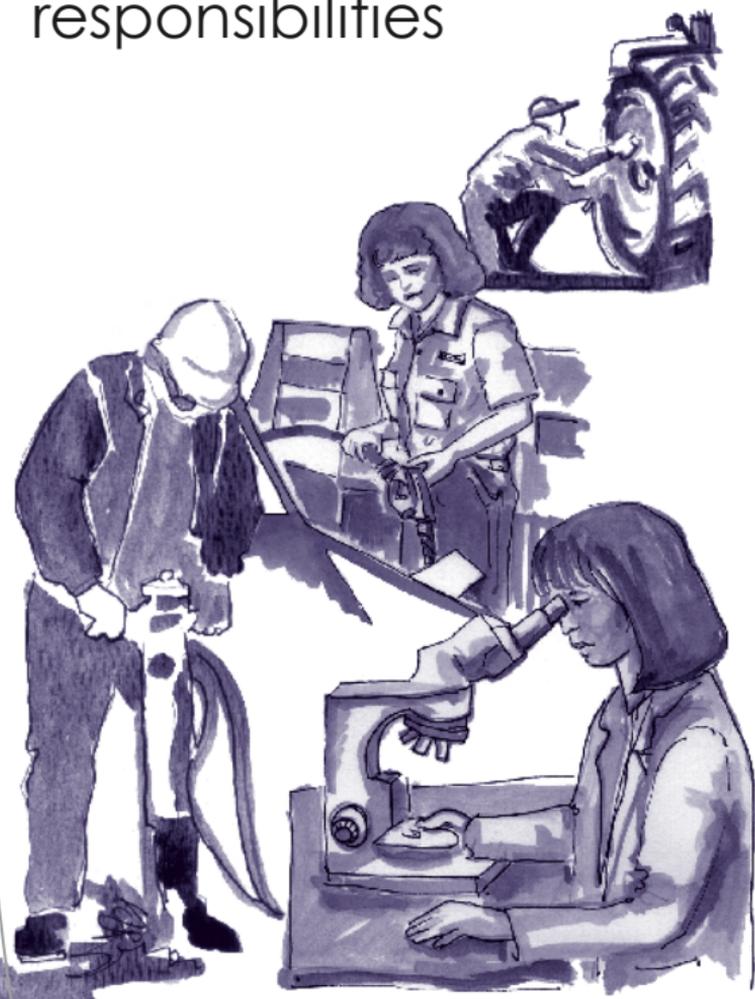


What happens if I'm hurt on the job?

A guide to Oregon's
workers' compensation
benefits, rights, and
responsibilities



January 2012

Claim Information Record

Insurer:

Phone:

Insurer representative:

Claim no.:

Date of injury:

Attending physician:

Employer's name:

Please complete the above claim information for your own record. This information is important and will help you navigate the workers' compensation system.

Protect your rights —

Stay in touch with your insurer, health care provider that you chose, and attorney (if you have one). You can get the name and phone number of your workers' compensation insurer from your employer.

The **Workers' Compensation Division (WCD)** can tell you about workers' compensation rights and responsibilities. WCD answers questions from injured workers, insurers, employers, attorneys, and medical providers. For more information, contact the workers' compensation helpline at 800-452-0288 or go to www.wcd.oregon.gov.

The **Ombudsman for Injured Workers** is the state office that serves as an independent advocate for injured workers by helping them understand their rights and responsibilities, investigating complaints, and acting to resolve those complaints. For more information, contact the injured worker helpline at 800-927-1271 or go to www.oregon.gov/DCBS/OIW.

You may want to consult with an attorney who specializes in workers' compensation. For more information, contact the **Oregon State Bar** referral service at 800-452-7636 or go to www.oregonstatebar.org.

To obtain a copy of this publication in Spanish, call the Workers' Compensation Division: 503-947-7627.

Para obtener una copia de esta publicación en español, llame la División de Compensación para Trabajadores: 503-947-7627.

To obtain a copy of this publication in Russian, call the Workers' Compensation Division: 503-947-7627.

Чтобы приобрести копию публикации на русском языке, пожалуйста, позвоните в Отдел Компенсаций Рабочих (Workers' Compensation Division): 503-947-7627.

The Oregon Workers' Compensation Division provides this booklet to Oregon workers with disabling claims. If you have comments or suggestions regarding this publication, contact the Workers' Compensation Division at 800-452-0288 or e-mail workcomp.questions@state.or.us.



In compliance with the Americans with Disabilities Act (ADA), this publication is available in alternative formats. Call the Workers' Compensation Division: 503-947-7810.

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Table of contents

First steps	5
How do I file a claim?	
How do I get medical treatment?	
How do I get interpreter services?	
If I can't work, will I receive payments for lost wages?	
Helpful tips	8
Claim status	8
What is an interim period?	
What is acceptance or denial of a claim?	
What if the insurer denies my claim based on an independent medical examination?	
Medical treatment	10
Do I have privacy rights at medical examinations?	
What are interim medical benefits?	
What medical bills will the insurer pay?	
What happens if my claim is denied and my health care provider sends me bills?	
Who can be my attending physician?	
What are the responsibilities of the health care provider?	
What if I want to change my attending physician?	
What if my health care provider recommends elective surgery?	
What if the insurer enrolls me in a managed care organization?	
What is an independent medical examination?	
What medical care am I entitled to after I become medically stationary?	
What is a new or omitted medical condition?	
Time-loss (temporary disability) payments	17
If I miss time from work, will I get paid?	
Is there a waiting period to receive benefits?	
How do you calculate wages to determine payments?	
Supplemental disability benefits	
Returning to work	20
What are my rights when returning to work?	
Are there benefits to staying at work or returning to work?	

What is modified work?

What re-employment assistance is available from the Workers' Compensation Division?

Do I qualify for vocational assistance?

Claim closure24

What is a Notice of Closure?

What is permanent partial disability?

What is permanent total disability?

What are fatality benefits?

What do I do if I disagree with the Notice of Closure?

What if my accepted condition gets worse?

Appeal rights and claim settlements27

What if I disagree with a decision?

What is a disputed-claim settlement?

What is a claim disposition agreement?

What are penalties for late payment?

Are my records confidential?

Glossary of workers' compensation terms30

Workers' compensation claim process flow chart34

Services directory36

Important information

- Throughout this booklet, we use the general term **“health care provider”** to describe a person or entity licensed to practice one of the healing arts such as a medical service provider, hospital, medical clinic, or vendor of medical services.
- **Health care providers may be limited in how long they may treat you and whether they may authorize payments for time off work.**
- **Check with your health care provider about any limitations that may apply.**

If you have additional questions, you may contact the insurer, the Ombudsman for Injured Workers, or the Workers' Compensation Division. You will find contact information in the back of the booklet.

First steps

How do I file a claim?

- If you believe you were injured at work or suffer from an illness because of your job, tell your employer as soon as possible.
- Ask your employer to give you **Form 801, “Report of Job Injury or Illness,”** complete the “worker” portion of the form, and give it back to your employer.
- Your employer will complete its portion and send the form to the workers’ compensation insurance company. Your employer will also give you a copy to keep for your records.
- Get the name and phone number of the workers’ compensation insurer from your employer. Your insurer is your primary contact, so stay in contact with them.
- Get medical treatment from a **health care provider of your choice** and tell your provider that you were injured on the job. Remember: Your employer cannot choose your health care provider for you.
- At your first visit, your health care provider should ask you to complete **Form 827, “Worker’s and Health Care Provider’s Report for Workers’ Compensation Claims.”** The provider will send the form to the insurer and give you a copy for your records.

Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers’ Compensation Division: 800-452-0288

How do I get medical treatment?

- You may receive medical treatment from a **health care provider of your choice** on the initial claim, including:
 - Authorized nurse practitioner
 - Chiropractic physician
 - Medical doctor
 - Naturopathic physician
 - Oral surgeon
 - Osteopathic doctor
 - Physician assistant
 - Podiatric physician
 - Other health care providers
- If your claim is accepted, the insurer only has to pay for medical treatment related to the accepted conditions listed on your “Notice of Acceptance.”
- If your claim is denied, you may have to pay for your medical treatment.
- The insurance company may enroll you in a ***managed care organization (MCO)*** at any time. If you are enrolled in a managed care organization, contact the insurer for more information about your medical treatment options.

How do I get interpreter service?

- You can choose any person to help you communicate with a health care provider if you and the provider speak different languages, including sign language. The insurer may pay for the interpretive services when the interpretation is for an accepted claim or condition; however, the insurer does not have to pay for the service if you choose to use a family member or friend.

Note: Information words that are in ***bold italics*** are defined in the Glossary, page 30. Agency phone numbers are listed in the Services directory, page 36.

- To schedule interpretive services, you may contact an interpreter service company, your doctor, or your insurer to arrange the service. The health care provider may disapprove of your choice of interpreter if he or she feels the interpretation is not complete or accurate.
- If the insurer determines the services are not related to an accepted condition, you may be responsible for payment. The interpreter services company should bill the workers' compensation insurer.
- For more information about interpreter services and your options, contact the Medical Section at 503-947-7606 or visit the Workers' Compensation Division's website at www.wcd.oregon.gov.

If I can't work, will I receive payments for lost wages?

- Your health care provider must authorize your absence from work. You should provide a copy of your off-work authorization be provided to your insurer as soon as possible.
- You will not be paid for the first three calendar days for your time off work unless you are off work for 14 days in a row or hospitalized overnight as an inpatient within the first 14 days.
- If your claim is denied within the first 14 days from the date you reported it to the employer, you will not be paid for any lost wages.

Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

Helpful tips

- Pay attention to information about medical appointments and time limits.
- If you fail to take action or if you miss a deadline to appeal claim decisions, you may lose your right to workers' compensation benefits. If you have questions about your claim or the documents you receive, call the insurer.
- Read all letters and notices about your claim, and keep copies of all letters you send and receive.
- Attend all medical appointments.
- Contact your employer immediately when your health care provider releases you back to work.
- Keep in contact with your doctor and inform your employer about your work restrictions. If your employer offers you a modified job or light duty, you must cooperate with their efforts to return you to work.

Claim status

What is an interim period?

The ***interim period*** begins when your employer first learns you have filed a claim, and it ends when the insurance company determines whether to accept or deny your claim. During the interim period, the insurer will only pay for limited medical treatment. For more information about the types of medical treatment covered during the interim period, see the "Medical treatment" section on page 10. For more information about time-loss benefits during the interim period, see the "Time-loss (temporary disability) payments" section on page 17.

The insurance company does not have to pay benefits if it denies your claim within 14 days of the date your employer knew about your claim.

Note: Information words that are in ***bold italics*** are defined in the Glossary, page 30. Agency phone numbers are listed in the Services directory, page 36.

What is acceptance or denial of a claim?

The insurer must accept or deny your claim within 60 days of the day your employer has notice or knowledge of the claim.

- If your claim is accepted, the insurer will send you a “Notice of Acceptance” that lists the specific medical conditions accepted.
- If you believe the insurer has not listed all the conditions caused by your injury, you must request, in writing, that the insurer add the missing condition(s) to your notice. If you believe that the notice is incomplete or incorrect, you must notify the insurer in writing of the error.
- If your claim is denied, the insurer must send you a letter specifying the reason(s) for denying your claim and notify you of your appeal rights.

What if the insurer denies my claim based on an independent medical examination (IME)?

If the insurer denies your claim based on an **independent medical examination (IME)**, you may be eligible for a **worker-requested medical examination (WRME)**, paid for by the insurer. In order to qualify for a WRME:

- The denial must be based on an IME,
- Your attending physician must disagree with the IME report, and
- You must request a hearing to appeal the claim denial.

If you meet these conditions and want to request a WRME, or need more information, contact the Workers’ Compensation Division at 800-452-0288 (toll-free).

Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers’ Compensation Division: 800-452-0288

Medical treatment

Do I have privacy rights at medical examinations?

You have the right to privacy at medical examinations. Your employer or the insurer cannot send a representative to your medical examinations without your written consent. If you do not consent, your benefits cannot be stopped or reduced.

What are interim medical benefits?

The interim period begins when your employer first learns you have filed a claim and it ends when the insurance company determines whether to accept or deny your claim.

During the interim period, the insurer will only pay for the following limited medical treatment:

- Diagnostic services required to identify appropriate treatment or to prevent disability.
- Medication required to alleviate pain.
- Services required to stabilize your claimed condition and to prevent further disability. Examples include, but are not limited to:
 - Antibiotic or anti-inflammatory medication,
 - Physical therapy and other conservative therapies, and
 - Necessary surgical procedures.
- If your claim is denied and you have a health benefit plan (health insurer), give that information to your health care provider and they will work with the health insurer and the workers' compensation insurer to get the bills paid up to the date of the denial.
- If your claim is denied and you **don't** have health insurance, you may be responsible for payment of your medical treatment.

Please note: The Oregon Health Plan is not considered a health insurer.

Note: Information words that are in ***bold italics*** are defined in the Glossary, page 30. Agency phone numbers are listed in the Services directory, page 36.

If you have any questions about your benefits during the interim period, call the workers' compensation insurer for more information.

What medical bills will the insurer pay?

If your claim is accepted, the insurer should pay for:

- Medical treatment related to your on-the-job injury,
- Prescription drugs, and
- Transportation, meals, and lodging necessary to attend medical appointments with some limitations.

Your health care provider should not bill you for medical services. Your provider should bill the workers' compensation insurer directly.

The pharmacy may be able to bill the insurer directly for prescriptions.

If you are required to pay for your prescriptions out-of-pocket, you will have up to two years from the date the expenses were incurred to send a written request for reimbursement with proof of expenses (copies of receipts) to the insurer. The insurer has 30 days to request additional information or reimburse you for your out-of-pocket expenses.

What happens if my claim is denied and my health care provider sends me bills?

If your claim is denied your health care provider is entitled to send you a copy of the bills.

If you appeal your denial, the provider may make no further attempt to collect payment from you until:

- All your appeals are completed, or
- You settle the claim.

If you do not appeal your denial then your health care provider can bill you.

If you have health insurance, the health care provider is required to bill your health insurer.

Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

Who can be my attending physician?

The term “**attending physician**” is used in the workers’ compensation system to designate the physician who is responsible for authorizing time-loss benefits and for overseeing the medical care you receive for your work injury. This could include overseeing care from other health care providers, such as physical therapists or other medical specialists, you may have to see in order to recover from the work injury. Under Oregon law, the following health care providers can be attending physicians:

- Medical doctors;
- Podiatric physicians;
- Doctors of osteopathy;
- Oral or maxillofacial surgeons;
- Chiropractic physicians, naturopathic physicians, and physician assistants who have certified to the director; and
- Medical providers designated to be attending physicians by a managed care organization.

What are the responsibilities of the health care provider?

Attending physicians:

- Authorize time-loss payments if you cannot work,
- Authorize reduced work hours or duties,
- Release you to go back to work, and
- Decide when you are **medically stationary**.

Emergency room physicians who do not serve as attending physicians may only authorize time loss for 14 days.

Even though chiropractic physicians, naturopathic physicians, and physician assistants can be an attending physician, they:

- May be your attending physician for only up to 60 consecutive calendar days or 18 visits, whichever occurs first.

Note: Information words that are in **bold italics** are defined in the Glossary, page 30. Agency phone numbers are listed in the Services directory, page 36.

Medical treatment

- May only authorize time-loss payments for 30 days from your first visit.
- May not make **impairment findings** except for chiropractic physicians.

Although **authorized nurse practitioners** are not designated as attending physicians, they:

- May treat you independently for up to 90 days,
- May authorize time-loss payments for up to 60 days,
- May authorize reduced work hours or duties for up to 60 days,
- May release you to go back to work within 60 days,
- May decide when you are medically stationary for up to 90 days, and
- Must refer you to an attending physician for a closing examination if you appear to have permanent impairment.

Providers who do not qualify to be an attending physician or an authorized nurse practitioner:

- May only treat you independently for 30 days or 12 visits, whichever occurs first,
- Are not allowed to authorize time-loss payments or to modify work, and
- Must be authorized by an attending physician or authorized nurse practitioner to provide additional treatment after 30 days or 12 visits.

What if I want to change my attending physician?

Since an attending physician is **primarily** responsible for your treatment, you may have only one attending physician at a time.

After your initial choice of an attending physician, you may change attending physicians two more times, by choice. Any more attending physician changes need approval from the insurer.

Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

To change your attending physician, fill out Form 827 at your new attending physician's office, and the attending physician will send the completed form to the insurer.

If the insurer does not approve the attending physician change, you may request approval from the Workers' Compensation Division.

The following are not considered a change of attending physician:

- A health care provider treats you in an emergency or as an "on-call" physician.
- Your attending physician sends you to a specialist, but remains primarily responsible for your care.
- You change health care providers due to a reason beyond your control such as:
 - Provider's treatment limitations,
 - You or your health care provider move out of the area, or
 - You become enrolled in a managed care organization.

If you are enrolled in a managed care organization, your rights may differ. Contact the insurer to find out more information.

What if my health care provider recommends elective surgery?

Elective surgery is surgery other than emergency surgery. Before scheduling elective surgery, the health care provider must notify the insurer, who may request a second opinion (managed care organization procedures may differ).

If the insurer disagrees about the need for surgery, the insurer must ask the Workers' Compensation Division to review the request for surgery to determine whether the surgery is appropriate.

Note: Information words that are in ***bold italics*** are defined in the Glossary, page 30. Agency phone numbers are listed in the Services directory, page 36.

What if the insurer enrolls me in a managed care organization?

If your employer is covered by a managed care organization contract, the insurer may enroll you with the managed care organization at any time after your injury. You may be required to select a managed care organization health care provider from a list of providers the insurer sends with your enrollment notice.

Until you are enrolled, any health care provider may provide medical treatment to you up to any treatment limitations they may have.

If you have a regular primary care physician who is a family practitioner, general practitioner, internal medicine specialist, or authorized nurse practitioner, he or she may be able to continue to provide treatment if he or she agrees to treat you according to the managed care organization contract.

What is an independent medical examination?

An independent medical examination is a medical exam of an injured worker by a physician other than the worker's attending physician. The IME is requested by the insurer. This doesn't include a consultation arranged by a managed care organization for an enrolled worker.

The insurer may require you to attend up to three medical examinations with health care providers it chooses.

You may be penalized \$100 or your workers' compensation benefits may be stopped if you fail to attend the exams.

The independent medical examination providers:

- Will not provide treatment.
- Will only prepare a report based on examining you to answer questions asked by the insurance company about your injury or occupational disease.
- May perform a physical- or work-capacity evaluation.

Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

If the independent medical examination provider intends to perform an invasive procedure. (An invasive procedure is one in which the body is entered by a needle, scope, or scalpel.):

- He or she must explain the risks,
- He or she must obtain your written agreement for this procedure, and
- Your benefits cannot be reduced or stopped if you decline an invasive procedure.

The insurer must pay all costs for the medical examination and will reimburse expenses necessary for you to attend the exam.

If you need advance payment in order to attend, or if you believe you need help attending the appointment because of your work-related injury, contact the insurer as soon as possible.

You may have a family member or friend accompany you to the examination, but the insurer is not required to pay that person's expenses.

To have a friend or family member present during the exam, you must complete, sign, and submit an "IME Observer Form" (440-3923A) to the independent medical provider.

What medical care am I entitled to after I become medically stationary?

When your health care provider determines that neither time nor treatment will improve your condition, you are considered medically stationary.

Medical benefits after you are found to be medically stationary may be limited to:

- Prescription drugs,
- Prosthetic devices, braces, supports,
- Diagnostic care,
- Curative care to stabilize your condition, and
- Life preserving treatment.

Note: Information words that are in ***bold italics*** are defined in the Glossary, page 30. Agency phone numbers are listed in the Services directory, page 36.

Contact the insurer or the Workers' Compensation Division if you have questions about covered services.

Palliative care, a medical service that makes you feel better but doesn't heal your condition, is covered if you are working and need the care to continue working or attend vocational training. The care is covered only if approved by the insurer or the Workers' Compensation Division.

What is a new or omitted medical condition?

A new condition is a condition that arises from the original injury. An omitted condition is a condition that was always there since the injury but was not accepted by the insurer. A worker may request the insurer to accept either a new or omitted condition at any time after the injury. That right continues even after your **aggravation rights** expire.

Time-loss (temporary disability) payments

If I miss time from work, will I get paid?

- If your health care provider authorizes you to take time off work or to do modified work that causes you to lose wages, you will receive time-loss payments from the insurer.
- Your first check will be mailed within 14 days from the date the insurer receives authorization from your health care provider.
- No payment is due for time missed from work that has not been authorized by your health care provider.

If you are unable to work, remind your health care provider each time you see him or her to send your time-loss authorization to the insurer. You can help ensure timely payments by contacting the insurer as soon as you begin to miss work.

Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

Time-loss benefits will **stop** if one of the following happens:

- Your health care provider fails to provide time-loss authorization,
- Your claim is denied,
- Your health care provider gives you a release to return to regular work,
- You return to regular work at full wages,
- A Notice of Closure closes your claim,
- You are incarcerated (incarcerated means in pretrial detention or in prison following conviction for a crime), or
- You remove yourself from the workforce.

Time-loss benefits will also be **reduced or stopped** if one of the following happens:

- Your health care provider approves a written offer of modified work and you refuse to take the job.
- Your health care provider approves work with your employer and your employer fires you (with cause).
- Your health care provider releases you to work, but you are unable to work because you are in the United States in violation of federal immigration laws.

Is there a waiting period to receive benefits?

Oregon has a three-day waiting period for benefits. You will not be paid for the first three calendar days for your time off work unless you are off work 14 days in a row or you are hospitalized overnight as an inpatient within the first 14 days.

The first day you lose time or wages will be the first day of the three-day waiting period.

If you are released for modified duty during the first 14 days, you will **not** be paid for the three-day waiting period.

Note: Information words that are in **bold italics** are defined in the Glossary, page 30. Agency phone numbers are listed in the Services directory, page 36.

How do you calculate wages to determine payments?

Payment for time lost from work is called **temporary total disability** or **temporary partial disability** and is based on your average weekly wage at the time of injury. The insurer may calculate your average weekly wage by averaging the wages you earned over the 52 weeks before your injury.

- Time-loss payments will equal two-thirds of your gross average weekly wage.
- Oregon has a minimum and maximum amount payable to an injured worker that is adjusted every year.
- If your doctor returns you to modified or light-duty work and you earn less money, you may be eligible to receive partial time-loss payments.
- Your average weekly wage is an important factor in calculating your time-loss benefits and it is important to verify your proper wage is being used in these calculations.

Supplemental disability benefits

You may be eligible to receive additional payments for time lost from other jobs; these payments are called supplemental disability. You must have had more than one Oregon subject job at the time of injury to be eligible for supplemental disability benefits.

- You must let the insurer know about your other jobs within 30 days of the day you filed the claim.
- To receive payment for any time lost from those other jobs, you must provide documentation of wages (check stubs or payroll records).
- You must provide the documentation within 60 days of the insurer's request or you may be found ineligible for supplemental disability.

Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

Returning to work

What are my rights when returning to work?

Most Oregon employers with more than 20 workers are required to return an injured worker to the worker's job or another suitable job after the worker is released to work.

- The insurer will send you written notice when your health care provider releases you to go back to work.
- When you receive this notice, you must ask your employer for your job or another suitable job within ***seven calendar days*** (sooner if your union contract or employer's personnel policies require it), or you will lose your right to be reinstated with your employer.
- When you receive any release for work, take it to your employer as soon as possible, as work may be available that is physically appropriate for you.

If you have questions about your rights or believe your employer has treated you unfairly because of your injury, call the Bureau of Labor and Industries, 971-673-0761 in the Portland area, or 541-686-7623 outside the Portland area.



Note: Information words that are in ***bold italics*** are defined in the Glossary, page 30. Agency phone numbers are listed in the Services directory, page 36.

Are there benefits to staying at work or returning to work?

Research shows that injured workers benefit from returning to work **at the earliest possible time** after an on-the-job injury.

Staying at work or returning to work as quickly as possible helps you prevent financial loss. When your health care provider manages your return to work, it can also help you recover from your injury faster.

What is modified work?

If your employer offers you modified work, contact your health care provider to find out if you are physically able to do the job. If your health care provider says you can do the modified job offered by your employer, you must accept the job or your time-loss benefits may be reduced or stopped. If you find after returning to work that you cannot do the job because of your injury, contact your health care provider immediately.

If you return to modified or light-duty work at a lower rate of pay or fewer hours, you will receive time-loss payments for the part of your wages you are missing. You may refuse a modified job without ending your time-loss benefits if **any** of the following is true:

- The job is **not** with the employer at injury or at a job site of the employer at injury (exception for home care workers).
- Your health care provider says you are physically unable to commute to the job site. (Your commute is the distance from your residence to your job at injury, or to the job you are offered as modified work.)

Questions?

Ombudsman for Injured Workers: 800-927-1271
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- The job site is more than 50 miles from where you customarily worked before your injury, unless that job site is less than 50 miles from your home. However, greater distance may be appropriate if the employer has multiple or mobile job sites and the injury you could have been assigned to any such site.
- The job's work schedule (shift) differs from the employer's written policy for changing work schedules, the common practice of the employer, or collective bargaining agreement.

What re-employment assistance is available from the Workers' Compensation Division?

The Employer-at-Injury Program helps workers stay on the job or get back to work with the employer at injury. Because of your injury, your employer may be eligible for benefits to assist in returning you to light-duty work while your claim is open.

The Preferred Worker Program helps injured workers get back to work by providing benefits to the employer at injury or any other Oregon employer. If you have permanent disability due to your injury, and your health care provider says you can't return to your regular job, you may qualify as a preferred worker.

If you are eligible for the Preferred Worker Program, you will receive an identification card and program materials shortly after your claim is closed.

If you think you should be eligible for Preferred Worker Program benefits and don't get an identification card soon after your claim is closed, call toll-free at 800-445-3948 or 800-696-7161 in Medford to ask whether you are eligible.

If you have questions or want to learn more about the Preferred Worker Program, contact a program representative toll-free at 800-445-3948 or 800-696-7161 in the Medford area.

Note: Information words that are in ***bold italics*** are defined in the Glossary, page 30. Agency phone numbers are listed in the Services directory, page 36.

Do I qualify for vocational assistance?

Vocational assistance includes help with job placement and training. You may qualify for assistance if **all** of the following are true:

- You have permanent disability, caused by the on-the-job injury,
- Your doctor did not release you to your regular job and you were not able to return to a job suitable that pays at least 80 percent of the wage you were earning, and
- You are authorized to work in the United States.

The insurer will determine if you are eligible for vocational assistance within 35 days of when you become medically stationary and notify you of its decision in writing. Contact the insurer if you need help getting back to work.

If you have questions, you may call the Workers' Compensation Division toll-free at 800-452-0288 or 800-696-7161 in the Medford area.



Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

Claim closure

What is a Notice of Closure?

Disabling claims are “open” or “active” while you are recovering from your injury and “closed” or “inactive” when you are medically stationary.

Your claim will also be closed if your injury is no longer the major cause of your disability or need for treatment, or if you fail to attend medical appointments. The insurer will send you the following important documents when your claim is closed:

- A legal document called a “Notice of Closure” that closes your claim. It lists the periods for which time-loss benefits were authorized and tells you how much permanent disability you may have. This document also tells you how to appeal the closure of your claim.
- An “Updated Notice of Acceptance at Closure” that lists the medical conditions the insurer has accepted. If the updated notice is incomplete or incorrect, notify the insurer in writing.
- A brochure, “Understanding Claim Closure and Your Rights,” explaining your appeal rights and the types of care covered by the insurer after claim closure.

After your time-loss payments end, you may be entitled to unemployment benefits (even if it would ordinarily be too late to qualify). You must apply within four weeks of the date of the Notice of Closure to see if you qualify for a special “base-year extension,” available to some injured workers. Contact the Oregon Employment Department office in your area for more information.

What is permanent partial disability (PPD)?

If the Notice of Closure shows you have ***permanent partial disability***, this means your injury resulted in a condition that has not returned to its normal or pre-injury status.

Note: Information words that are in ***bold italics*** are defined in the Glossary, page 30. Agency phone numbers are listed in the Services directory, page 36.

You may be entitled to receive payment from the insurer for your disability. Permanent disability payments are based on a formula set by law. The amount will depend on the severity of the disability and whether you received overpayment of benefits. If the insurer overpaid you for benefits while your claim was open, the insurer may recover the overpayment by reducing your permanent disability payment or by reducing future benefits. Here are some things to keep in mind about permanent partial disability benefits:

- Permanent disability award payments are due to start 30 days from the mailing date of the closure.
- If your award is \$6,000 or less, the insurer will pay you a lump sum.
- If your permanent partial disability award is more than \$6,000, the insurer will make monthly payments to you until the award is paid. Your monthly award payments are equal to your monthly temporary total disability rate.
- You may ask the insurer to pay you a ***lump sum***. However, if you or the insurer appeals the amount of your permanent disability award, you cannot receive a lump-sum payment until the appeal process is finished and the order is final. **If you apply for and accept lump-sum payment of any part of your permanent disability award, you give up your right to appeal the amount of the award.** You are not eligible to receive your payment in a lump sum if you are taking part in a vocational training program.

What is permanent total disability (PTD)?

If the Notice of Closure shows you have ***permanent total disability***, it means you are permanently unable to perform gainful and suitable employment. You will receive monthly disability payments as long as you remain totally disabled. The insurer will re-examine your claim at least every two years to see if you remain unable to work.

Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

What are fatality benefits?

When a worker dies due to an on-the-job injury or occupational disease or illness, and the insurer accepts the claim, Oregon law requires insurers to make monthly payments to the worker's spouse, children, and other eligible beneficiaries. The insurer will pay for disposition and funeral expenses subject to a maximum amount. If you die while receiving permanent total disability benefits, your spouse or other eligible beneficiaries may be entitled to continuing benefits.

What do I do if I disagree with the Notice of Closure?

If you disagree with the Notice of Closure, you must write to the Workers' Compensation Division within 60 days of the mailing date printed on the Notice of Closure. Your appeal rights and the address to send your appeal are printed on the back of the Notice of Closure.

You may also fill out and send the form "Worker's Request for Reconsideration" to the Workers' Compensation Division. You can obtain the form by contacting the division and asking for a copy of the form to be mailed to you, or going to the division's Web site, www.wcd.oregon.gov. Click on "Forms," then click "Forms by category." Select "Requests to the Workers' Compensation Division for review of a decision or resolution of a dispute." The Worker's Request for Reconsideration, Form 2223A, is available in several formats for you to download, print, and fill out. For more information or assistance, call the Workers' Compensation Division at 800-452-0288 (toll-free) and ask to speak with an appellate reviewer.

What if my accepted condition gets worse?

If your accepted condition gets worse after your claim is closed, you have the right to seek medical care. You may ask the insurer to reopen your claim by filing a Form 827 at your attending physician's office. The health care provider will submit the paperwork to the insurer on your behalf.

Note: Information words that are in ***bold italics*** are defined in the Glossary, page 30. Agency phone numbers are listed in the Services directory, page 36.

Aggravation rights on disabling claims expire five years from the first closure date of the claim. Aggravation rights on a nondisabling claim expire five years from the date of injury.

After the five-year rights expire, you may still have some rights to additional benefits. If you need hospitalization, surgery, or other curative treatment in lieu of hospitalization, the insurer may reopen the claim and pay time-loss benefits that are authorized by the attending physician until your conditions are again declared medically stationary.

If you request acceptance of a new or omitted medical condition after your aggravation rights expire, you may also be eligible to receive a permanent disability award if your condition has permanently worsened more than when your claim was last closed.

Appeal rights and claim settlements

What if I disagree with a decision?

You can appeal any decision made about your claim. An “appeal” is a request by an injured worker, an insurer, or another party to a claim for a review of a decision made about the claim. If you receive a notice that your claim or benefits are denied or ended, the document you receive will have instructions on how to appeal if you disagree with the decision. **There are time limits for most appeals. You’ll lose your appeal rights if you don’t appeal within the limits as printed in the letter or notice you received.**

Benefits that are the subject of the appeal are usually not paid until the appeal process (*litigation*) is completed. If you want legal advice, check the yellow pages of your phone directory under “Attorneys” or call the Oregon State Bar, 800-452-7636 (toll-free), to find a lawyer who handles workers’ compensation cases in your area.

Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers’ Compensation Division: 800-452-0288

What is a disputed-claim settlement?

If you and the insurer disagree about whether you have a valid workers' compensation claim or condition, you and the insurer may resolve the disagreement by a ***disputed-claim settlement***.

A disputed-claim settlement (DCS) is settlement of a claim when there is a disagreement about compensability. In a DCS, you release all rights and benefits associated with the claim (for an agreed upon sum of money). This means your claim will remain denied, and you will give up all rights to future benefits for the denied medical conditions of the claim.

Health care providers may bill you for services not paid by the insurer, so be sure to know what your obligations will be under the agreement before you agree to a settlement.

What is a claim disposition agreement?

If you have an accepted claim, you may exchange your rights to the claim for money through a ***claim disposition agreement***. In such an agreement you may give up your rights to one or more of the following claim benefits:

- Present and future time-loss benefits.
- Present and future permanent partial disability awards.
- Monthly payments for permanent total disability.
- Vocational assistance benefits.
- Aggravation rights to reopen your claim.
- Survivor benefits.

You cannot give up your right to medical benefits or your eligibility for the Preferred Worker Program.

Note: Information words that are in ***bold italics*** are defined in the Glossary, page 30. Agency phone numbers are listed in the Services directory, page 36.

The Workers' Compensation Board must approve all claim disposition agreements unless the settlement was negotiated during a mediation. In this instance, the administrative law judge who mediated the dispute can approve the settlement document. If you have a question about the claim disposition agreement, you may contact the Ombudsman for Injured Workers at 800-927-1271 (toll-free).

What are penalties for late payment?

If you believe that the insurer delayed accepting or denying your claim or delayed payment of benefits past their due date, you may write to the Workers' Compensation Division and request that the insurer be penalized. If the Workers' Compensation Division finds that a penalty is appropriate, the insurer will pay the penalty amount to you and your attorney if you are represented.

Are my records confidential?

Claim information on file with the Workers' Compensation Division and medical and vocational claim records on file with the insurer may be released only in limited circumstances, such as:

- When you or your attorney requests copies,
- When necessary for the insurer to process your claim,
- When necessary for government agencies to carry out their duties, or
- When otherwise required or allowed by law.

Employers may not legally consider workers' compensation injuries in making their hiring decisions.

Questions?

Ombudsman for Injured Workers: 800-927-1271
Workers' Compensation Division: 800-452-0288

Glossary of workers' compensation terms

In this booklet, you will find the following terms:

aggravation claim: A claim for further benefits because of a worsening of the claimant's accepted medical condition after the claim has been closed. An aggravation is established by medical evidence supported by objective findings observed or measured by the physician. **Aggravation rights** expire five years after first closure on disabling claims or five years from date of injury on nondisabling claims. An attending physician who is a licensed medical doctor, doctor of osteopathy, a podiatric physician, or oral and maxillofacial surgeon, must file a Form 827 and a medical report with the insurer within five consecutive calendar days of the worker's visit to make a claim for aggravation. The insurer has 60 days to accept or deny a claim for an aggravation. ORS 656.273

attending physician (AP): A doctor or physician who is primarily responsible for the medical care of a worker by either directly treating the worker or by approving and directing care provided by others. The attending physician must be a licensed medical doctor, doctor of osteopathy, a podiatric physician, oral and maxillofacial surgeon, or medical provider designated to be an attending physician by the managed care organization (MCO). A chiropractic physician, naturopathic physician, or physician assistant on the WCD health care provider certification list can be an attending physician for up to 60 calendar days or 18 visits (whichever occurs first) and authorize time-loss benefits for up to 30 calendar days from the first day the patient sees any provider on the WCD health care provider certification list.
ORS 656.005

authorized nurse practitioner: A nurse practitioner authorized by the Workers' Compensation Division may provide compensable medical services to an injured worker for a period of 90 consecutive calendar days from the date of the first nurse practitioner visit on the initial claim. A nurse practitioner may also authorize the payment of temporary-disability benefits for a maximum of 60 calendar days from the date of the first nurse practitioner visit on the initial claim. Authorized nurse practitioners cannot make impairment findings. Nurse practitioners authorized to treat by managed care organizations may treat longer than 90 days. ORS 656.245

claim disposition agreement (CDA and C&R): An agreement between the parties to a workers' compensation claim. The worker agrees to sell back his or her rights (e.g., rights to compensation, attorney fees, and expenses) except rights to medical benefits or preferred worker benefits on an accepted claim. Also known as a "C&R" or a "compromise and release."

disabling injury: An on-the-job injury that entitles the worker to disability compensation or death benefits. ORS 656.005

disputed-claim settlement (DCS): Settlement of a claim when there is disagreement about compensability. For an agreed upon sum of money, the worker releases all rights and benefits associated with the claim.

employer knowledge date (EKD): The date an employer has knowledge of a worker's injury.

health care provider: A person or organization licensed to practice one of the healing arts such as a medical service provider, a hospital, medical clinic, or vendor of medical services.

impairment findings: A measurement by a physician of loss of use or function of a body part or system.

independent medical examination (IME): Any medical examination including a physical capacity or work capacity evaluation, or consultation requested by the insurer and completed by a medical service provider other than the worker's attending physician.

injury: An on-the-job injury or occupational disease.

interim period: The time between when an employer first has knowledge or notice about a claim and when the insurance company accepts or denies the claim.

insurer: An insurance company, self-insured employer, or self-insured employer group that provides workers' compensation coverage to employers and benefits to injured workers.

litigation: A process that usually results in a judge deciding the resolution of the dispute based on the facts and the law.

lump sum: The payment of a permanent partial disability award in one check (for awards that are more than \$6,000) usually upon request of the worker. Awards that are less than \$6,000 are always paid in a lump sum.

managed care organization (MCO): An organization that contracts with an insurer to coordinate medical services to injured workers. ORS 656.260

medically stationary: An injured worker is considered medically stationary when the attending physician determines no further significant improvement to the worker's condition that resulted from the injury or illness can reasonably be expected either from medical treatment or the passage of time. ORS 656.005

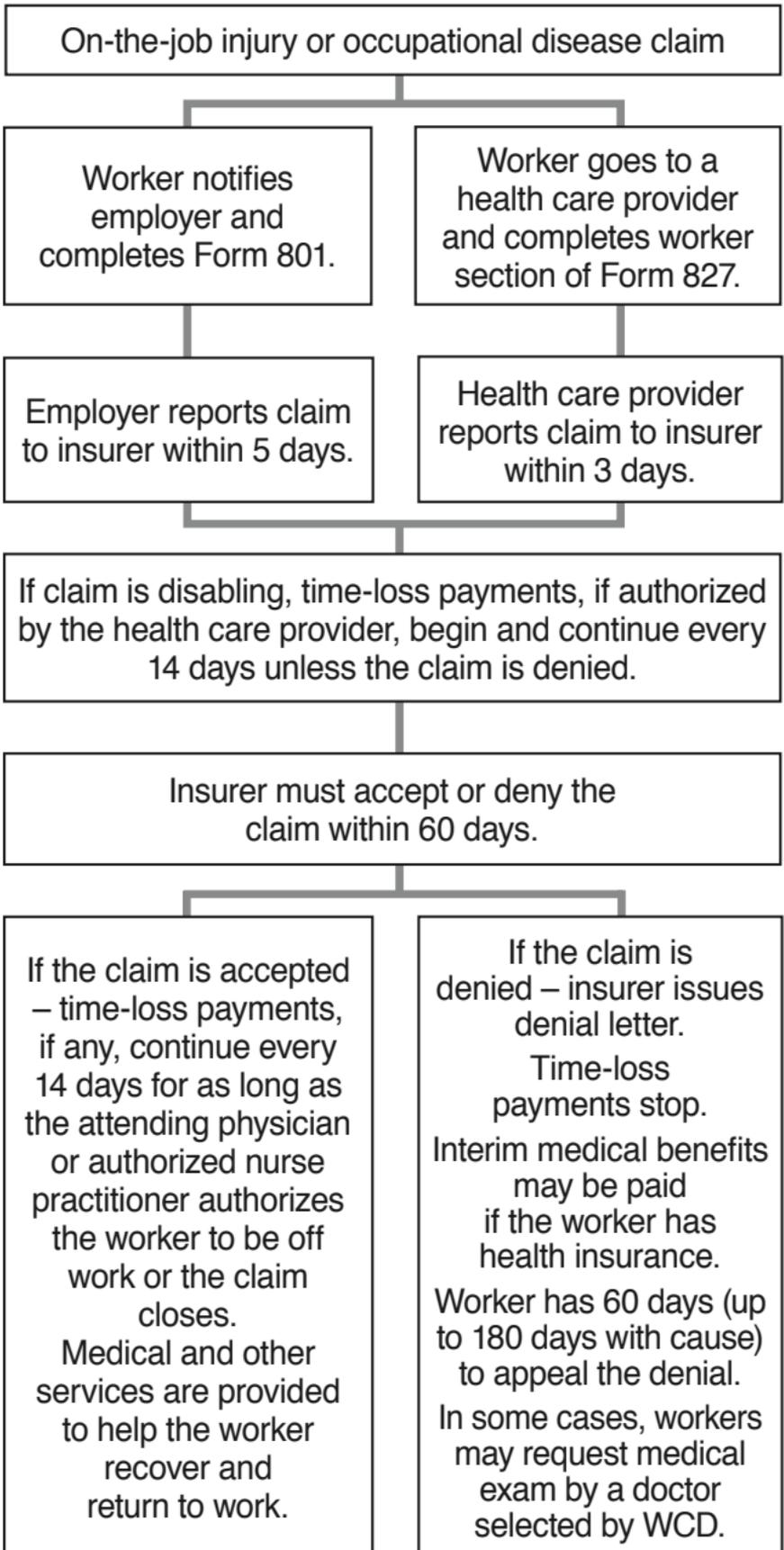
nondisabling injury: Any injury that requires only medical services with no inability to work beyond the first three days and does not result in any measurable permanent disability. ORS 656.005

occupational disease: A disease or infection resulting from a worker's job. It is caused by substances or activities an employee is exposed to at work and results in medical services, disability, or death. ORS 656.802

- Ombudsman for Injured Workers:** The Department of Consumer and Business Services office that serves as an independent advocate for injured workers by helping them understand their rights and responsibilities, investigating complaints, and acting to resolve those complaints. ORS 656.709
- permanent partial disability (PPD):** The permanent loss of use or function of any portion of the body as defined by ORS 656.214.
- permanent total disability (PTD):** The loss of use or function of any portion of the body in combination with any pre-existing disability that permanently prevents the worker from regularly performing gainful and suitable work. ORS 656.206
- supplemental disability:** The increase of disability payments due a worker employed in more than one Oregon subject job at the time of injury.
- temporary partial disability benefits (TPD):** Payment for partial loss of wages when a worker can work only part time or light duty after an injury. ORS 656.212
- temporary total disability benefits (TTD):** Payment for loss of all wages after an injury when the worker can't return to any work. ORS 656.210
- time-loss payments:** Payments to an injured worker who loses time or wages because of a compensable injury. ORS 656.210
- Workers' Compensation Board (WCB):** The part of the Oregon Department of Consumer and Business Services responsible for conducting hearings and reviewing legal decisions and agreements affecting injured workers' benefits.
- Workers' Compensation Division (WCD):** The division within the Oregon Department of Consumer and Business Services that administers the state's workers' compensation laws.
- worker-requested medical exam (WRME):** An examination available to a worker whose claim has been denied based on an independent medical exam where the injured worker's physician does not agree with the findings.

Workers' compensation claim process

From injury through acceptance or denial:



From acceptance through closure and beyond:

Worker and insurer may make a claim disposition agreement (at any time after claim acceptance), subject to approval by the Workers' Compensation Board.

The claim will be closed when the worker is medically stationary.

The claim is closed and a decision is made about the amount of worker's disability, including permanent partial disability (PPD), if any. A Notice of Closure is issued by the insurer.

Vocational assistance is provided if worker is eligible (at any time after claim acceptance).

If worker cannot return to regular work and has permanent disability, WCD issues a Preferred Worker Card, which allows worker to offer hiring incentives to Oregon employers.

Insurer (within 30 days of the notice of closure) must begin payment of PPD, if any. However, if the claim closure is appealed, payment may be stayed (not paid) until the litigation is completed.

Insurer, within seven days, or worker, within 60 days of claim closure, may request reconsideration by the WCD Appellate Unit.

After the claim is closed, worker remains eligible for certain medical and vocational services. If the accepted condition worsens, the claim may be reopened for additional disability and other benefits.

Services directory

Workers' Compensation Division

350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405
www.wcd.oregon.gov
workcomp.questions@state.or.us

Workers' compensation infoline	800-452-0288
General information	503-947-7810
Benefits information	503-947-7585
WCD Employer Index (to verify employer's insurance)	888-877-5670
Managed care organization, medical fee, medical treatment, curative care, palliative care disputes, and interim medical benefits.....	503-947-7606
Reconsideration of claim closures	503-947-7816
Re-employment assistance	503-947-7588
Toll-free	800-445-3948
Medford office (toll-free).....	800-696-7161
Vocational eligibility/assistance, return-to-work plans, and vocational disputes	503-947-7816

Ombudsman for Injured Workers

350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405
www.oregon.gov/DCBS/OIW
oiw.questions@state.or.us

General information	503-378-3351
Injured worker infoline.....	800-927-1271

Workers' Compensation Board (and Hearings Division)

2601 25th St. SE, Suite 150
Salem, OR 97302-1280

www.wcb.oregon.gov

General information	503-378-3308
Salem (toll-free)	877-311-8601
Portland (toll-free)	866-880-2078

Other resources

This booklet explains workers' compensation benefits. Even if your claim has been denied or you have exhausted your workers' compensation benefits, you may be eligible for some other types of assistance.

- Contact the **Oregon Employment Department** to find out if you are eligible for unemployment benefits. www.employment.oregon.gov
- Contact the **Social Security Administration** to find out if you are eligible for disability benefits.
- Contact the **Oregon Office of Vocational Rehabilitation Services** to find out if you are eligible for rehabilitation services. www.oregon.gov/DHS/VR/
- Contact the **Oregon State Bar** for lawyer referral services information. www.oregonstatebar.org

If you have questions about injured workers' employments rights, contact the **Civil Rights Division, Bureau of Labor and Industries** (workers' compensation discrimination issues):

www.oregon.gov/BOLI/CRD/index.shtml

Portland: 971-673-0761
Eugene: 541-686-7623
Salem: 503-378-3292



Oregon Department of
Consumer & Business Services
Workers' Compensation Division
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